STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035254	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow Campus of Care	826 West Desmond Street Winslow, AZ 86047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on clinical record review, facility documentation, observation, staff interviews, and policy review, the facility failed to ensure that two residents (#25 and #20) were free from physical abuse. The deficient practice could result in further incidents of resident to resident abuse and lead to injury. Findings include: -Regarding Resident #25: -Resident #25 was readmitted to the facility on [DATE], with diagnoses that included dementia with other behavioral disturbances, other pulmonary embolism, cardiomyopathy, and pulmonary fibrosis. Review of an annual minimum data set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment score of 3, indicating severe cognitive impairment. The MDS further indicated that the resident had noted physical behavioral symptoms directed toward others. A care plan dated February 15, 2021, revealed that Resident #25 may exhibit behaviors of physical aggression toward staff and other residents, with interventions to avoid placing the resident in area of other residents if agitated, to redirect the resident with activities she enjoys, and to document behaviors. A progress note dated February 28, 2025, revealed that at 5:44 PM, a dementia aide notified the nurse of a possible resident to resident altercation. The camera footage was reviewed and confirmed that physical contact was made. Resident #25 approached the other resident in the hallway and attempted to interact verbally. The other resident ignored Resident #25 at first, then became agitated and began swatting at Resident #25's left leg. Resident #25 then shoved Resident #20 on the right shoulder. Resident #20 again swatted at Resident #25's left leg, and Resident #25 shoved Resident #20 on the right shoulder a second time. A dementia unit aide intervened at that time. The residents were separated and assessed with no injuries noted. Appropriate notifications were made. -Regarding Resident #20: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035254	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow Campus of Care	826 West Desmond Street Winslow, AZ 86047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #20 was readmitted to the facility May 11, 2023, with diagnoses that included vascular dementia with other behavioral disturbance, unspecified mood disorder, cerebral infarction, and aphasia. A quarterly minimum data set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment was not conducted due to the resident being rarely or never understood. A care plan dated December 17, 2015, indicated that Resident #20 has exhibited behaviors of physical / verbal aggression of pushing others and yelling at other residents, with interventions to redirect the resident and remove from the area, to talk to her in brief statements and allow time to answer, and to distract her with activities including coffee, cards, and sewing, and to document her behaviors. An Event note dated February 28, 2025, revealed that at 5:44 PM, a dementia unit aide informed the nurse of a possible resident to resident altercation. The camera footage was reviewed and confirmed that physical contact was made between the two residents. A progress note dated March 1, 2025, revealed that Resident #20 was on alert charting for a resident to resident altercation. There was no bruising to the resident's right hand or shoulder, no complaints of pain, and no discomfort noted. The note revealed that camera footage was reviewed and confirmed that there was physical contact between two residents, Resident #20 and Resident #25. At first, Resident #20 ignored Resident #25, however Resident #25 continued to try to interact with Resident #20. Resident #20 became agitated and swatted at Resident #25's left leg. Resident #25 then in return shoved Resident #20 on the right shoulder. Resident #20 then swatted again at Resident #25's left leg, and Resident #2 shoved Resident #20 again on the right shoulder a second time. A dementia unit aide intervened at that time, the residents were separated and assessed with no injuries noted. Appropriate notifications were made. A Behavior Charting note dated March 1, 2025, revealed the resident was in an altercation with another resident and that the cause of the behavior was that Resident #20 is non-verbal and did not want to be bothered by the other resident. An observation was conducted on March 3, 2025, at 1:34 PM, of the video footage of the resident to resident altercation in the hallway of the 400 unit on February 28, 2025. Resident #20 was sitting in her wheelchair outside of the doorway of a room, facing the hallway. Resident #25 wheeled her wheelchair out of a room and approached Resident #20 from behind and on the right side of her. Resident #25 attempted to talk to Resident #20, who then appeared to become agitated. Resident #20 then turned toward Resident #25 and struck her multiple times in the left leg with her hand. An interview was conducted on March 3, 2025, at 1:34 PM, with a Registered Nurse and Behavioral Unit Manager (RN / Staff #6), who stated that she was informed by the dementia unit aide that the aide had heard yelling on the unit and got up and saw Resident #20's hand moving at Resident #25. The aide informed the RN that the residents had been separated, and the RN assessed both residents and there were no injuries. The RN stated that the aide had informed her immediately after the incident, and that within 5-10 minutes of the incident the camera footage was reviewed, and a report was made to the administrator and Director of Nursing (DON) right away. The RN stated that when reviewing the camera footage, that it was determined that physical contact occurred between the residents and that it was aggressive in nature. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035254	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow Campus of Care	826 West Desmond Street Winslow, AZ 86047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the DON (Staff #39) on March 3, 2025, at 1:51 PM. The DON stated that she had been informed of the resident to resident altercation, and that she had reviewed the camera footage and observed Resident #25 roll her wheelchair out of a room and try to talk to Resident #20. Resident #20 struck out at Resident #25's leg and that the DON believed there was physical contact. The DON stated that moving forward from this incident, that the facility was coordinating with the provider team to review the residents' medications, that additional staff were present on the unit to supervise, and that the residents are being kept in separate areas on the unit. The DON stated that abuse is prohibited in the facility. Additionally, the expectation for staff if abuse is alleged to occur is to report it immediately and within 2 hours, and to follow policies and procedures. The DON stated that the impact on residents if abuse occurs could be a negative impact on the physical or mental health of a resident. Review of the facility policy titled Abuse Prevention and Procedure, revised June 2024, revealed that it is the policy of the facility to take appropriate step to prevent the occurrence of abuse. Violations or alleged violations will be reported to the State agencies in accordance with State laws, and will be thoroughly investigated by the Administrator or designee. Abuse is defined as the willful infliction of injury with physical abuse further described to include, but not limited to, hitting, slapping, punching, biting, pinching, and kicking.